MEDICAL RELEASE AUTHORIZATION FROM FULL CIRCLE NUTRITION

Lora Williams, MS, RD, LD
721 N. Locust Street
Denton, TX 76201
(940) 380-8780
(940) 380-8788 (fax)

I hereby authorize Lora Williams, MS, RD, LD of Full Circle Nutrition to release all nutrition consult reports to:

Patient Name ______________________________ Patient Telephone____________________

Patient Address ____________________________ City/State/ Zip______________________

Reason / Purpose for release: *(please circle)* personal records; Specialist; Insurance; Other_____________

Please also release my nutrition consult report to the person(s)/MD listed here: ______________________

______________________________ ____________________ ________ ______
Street Address or PO Box City State Zip

Please Note: Your nutrition consult report(s) is/are sent to your referring provider unless you specify otherwise.

Expiration: This authorization will expire on (must choose one):

☐ One year from the date it is signed ☐ Other (insert date or event):____________________

Right to Revoke: I understand that I may revoke this authorization at any time by giving written notice to the address listed at the top of this form. **I understand that revocation of this authorization will not affect any action the above named entity took in reliance on this authorization before the above named entity received my written notice of revocation.**

Signature (this document must be signed by the individual, parent of minor child or the individual's personal representative):

______________________________ ____________________ ________
*Signature of Patient / Patient's Personal Representative*** *Printed Name* *Date Signed*

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Relationship if not Patient

Reviewed / revised 4/2012

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